Bureau of Health Care Quality & Compliance

AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVN2611AGC	B. WING			07/14/2009	
NAME OF PR	OVIDER OR SUPPLIER	NOTE OF THE O	STREET ADD	RESS. CITY. STA	ATE. ZIP CODE	<u> </u>	2003
NAME OF PROVIDER OR SUPPLIER  RIVER FLOW MANOR 1			STREET ADDRESS, CITY, STATE, ZIP CODE  327 RIVER FLOW DRIVE RENO, NV 89523				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation initiated on 6/30/09 and completed during the annual State Licensure survey conducted in your facility on 7/14/09. This State Licensure survey was conducted by the authority of NRS 449.150,		d as s, ral, ed as on ate				
V 070	Powers of the Health The facility is license Facility for Group ber persons, Category II time of the survey wa reviewed and three er reviewed. One disch reviewed. The facility The following deficient	d for seven Residential ds for elderly and disable residents. The census as six. Six resident files employee files were harged resident file was y received a grade of Duncies were identified:	led at the were	V 070			
Y 070 SS=F	training  NAC 449.196 1. A caregiver of a refacility must: (f) Receive annually hours of training relafor the needs of the residential facility.  This Regulation is no Based on record revi	not less than 8 ted to providing	: lity	Y 070			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 07/23/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2611AGC 07/14/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 327 RIVER FLOW DRIVE **RIVER FLOW MANOR 1 RENO. NV 89523** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 070 Continued From page 1 Y 070 eight hours of annual training (Employee #1) Severity: 2 Scope: 3 Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=F Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Based on record review on 7/14/09, the facility failed to ensure that 1 of 2 caregivers had completed the required three hour medication

management refresher training every three years

This was a repeat deficiency from the 7/25/08

(Employee #1).

State Licensure survey.

Severity: 2 Scope: 3

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This Regulation is not met as evidenced by: Based on record review on 7/14/09, the facility failed to ensure 1 of 2 caregivers met background

check requirements (Employee #1).

Severity: 2 Scope: 3

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPLETED		
	NVN2611AGC						07/14/2009	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	REET ADDRESS, CITY, STATE, ZIP CODE				
RIVER FLOW MANOR 1			327 RIVER FLOW DRIVE RENO, NV 89523					
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Y 106	Continued From page 3			Y 106				
Y 106 SS=F	449.200(2)(a) Persor	R	Y 106					
	information required (a) A certificate statin currently certified to p cardiopulmonary resu	st include, in addition to pursuant to subsection og that the caregiver is perform first aid and	1,					
	Based on record review on 7/14/09, the facility							

failed to ensure that 1 of 2 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #1).

Severity: 2 Scope: 3

Y 174 449.209(4)(a) Health and Sanitatio-Offensive SS=F odors

Y 174

## NAC 449.209

- 4. To the extent practicable, the premises of the facility must be kept free from:
- (a) Offensive odors.

This Regulation is not met as evidenced by: Based on observation on 6/12/09 and 7/14/09, the facility did not ensure 2 of 4 bedrooms and the hallway were free of offensive urine odors (Resident rooms #2 and #3).

Severity: 2 Scope: 3

PRINTED: 07/23/2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2611AGC 07/14/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 327 RIVER FLOW DRIVE **RIVER FLOW MANOR 1 RENO. NV 89523** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 250 Y 250 449.217(1) Kitchens-Equipment works; Clean SS=F and Sanitary NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. This Regulation is not met as evidenced by: Based on observation and interview on 7/14/09. the food preparation areas were not clean allowing for the sanitary preparation of food (excessive food debris and grease on counters, inside cupboards, microwave and toaster oven). Severity: 2 Scope: 3 Y 434 449.229(3) Emergency Drills Y 434 SS=E NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill.

This Regulation is not met as evidenced by: Based on record review on 7/14/09, the facility did not ensure that monthly evacuation drills were

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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BIVER ELOW MANOR 4			327 RIVER RENO, NV	ER FLOW DRIVE				
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Y 434	Continued From page 5			Y 434				
	conducted on an irregular schedule for the past 1 of 12 months (June of 2009).							
	Severity: 2 Scope: 1							
Y 444 SS=E	NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.			Y 444				
	Based on record review	ot met as evidenced by: ew on 7/14/09, the facil e detectors were tested s (June of 2009).	ity					
	Severity: 2 Scope: 1							
Y 451 SS=F	449.231(2)(a)-(f) Firs	t Aid Kit		Y 451				
	The first-aid kit must (a) A germicide safe t (b) Sterile gauze pad (c) Adhesive bandage adhesive tape; (d) Disposable gloves (e) A shield or mask t is administering cardi	s; es, rolls of gauze and	who on;					

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medication administration in resident medication administration records (MAR) at the time of the administration for 5 of 6 residents (Resident #1, #2, #3, #4 and #5 - medications were not

documented for days at a time.

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